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Health Zones, Co-Management, and Decentralization in Benin

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Partnerships for Health Reform

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Abstract

This report reviews the decentralization of the territorial government into communes and the establishment of health zones as part of Benin's health reform measures. As these territorial reforms can cause a considerable upheaval in the institutional framework to implement health activities, the report identifies ways to make the decentralization of the territorial government consistent with the reform of health service delivery.

A study team visited Benin's three geographic areas and interviewed numerous officials and resource persons in four health zones of varying functionality. The team found that potential difficulties linked to the mismatch between the division into zones and the division into communes seem to have been overestimated, as communal powers stop at the *arrondissement* and health committees can facilitate cooperation among communes and between communes and communities.

Detailed recommendations include procedures for community monitoring of health service operation; decision-making mechanisms for effective daily operational management; and procedures for effective coordination on policy and service delivery between different health organizations and sectors.

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Acronyms

AMAE	Association municipale d'actions environnementales
APE	Parent Teachers Association
APNV	Approche Participative de Niveau Village
CADZS	Cellule d'Appui au Développement des Zones Sanitaires
CAME	Centrale d'achat de médicaments
CARDER	Centre d'action régionale de développement rural
CCS	Complexe communal de santé or Commune Health Centers
CHD	Centre hospitalier du département or Department Health Centers
COGEC	Comité de gestion communautaire or community health committee
COGES	Comité de gestion de la sous-préfecture or sub-prefecture health committee
CREDESA	Centre Régional de Développement des Services de Santé or Regional Center for the Development of Health Services
CSSP	Sub-Prefecture Health Centers
DDSP	Directeur départemental de la santé publique
GTZ	Deutsche Gesellschaft fuer Technische Zusammenarbeit
HZ	Health zone
NGO	Non-governmental organization
PBA/SSP	Projet Bénino-Allemand des Soins de Santé Primaires or Benin-Germany Primary Health Care Project
PDSP	Projet de Développement de la Santé de Pahou
UVS	Unités villageoises de santé or Village Health Units

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Executive Summary

This report reviews the decentralization of the territorial government into departments and communes and the establishment of health zones as part of Benin's health reform measures. As these territorial reforms can cause a considerable upheaval in the institutional framework to implement health activities, the report identifies ways to make the decentralization of the territorial government consistent with the reform of health service delivery into health zones.

Benin began discussing health system reforms in 1995 at the first Health Sector Roundtable, focusing on policies and strategies that would upgrade quality and accesibility of health care and also strengthen community participation. During the course of territorial government reform, a certain number of health-related powers were transferred to the communes. With the development of health zones, effective co-management of these overlapping areas has become an urgent issue.

A study team consisting of an institutional development expert, a health services manager, and a social anthropologist visited Benin's three geographic areas and interviewed numerous officials and resource persons in four health zones which were functioning with varied success.

Results of this survey include proposed procedures for monitoring the operation of health services and service providers by community representatives. It identifies management and decision-making mechanisms for the day-to-day operation of the system. These include resource allocation, budget allocation, ordering supplies and equipment, and managing maintenance programs.

It also identifies procedures and means for coordination between different health organizations, both in terms of policy and service delivery. The report includes recommendations for carrying out joint activities with other sectors at the commune and health zone level. These include raising funds to cover the cost of health services and exercising responsibilities for aspects of environmental sanitation.

The team found that the potential difficulties linked to the mismatch between the division into zones and the division into communes seem to have been overestimated, because the scope of powers identified by the law is not creating a place for the joint exercise of responsibilities among communes; their powers stop at the *arrondissement*. Furthermore, the creation of the health committee gives a face to cooperation between communes on the one hand, and between communes and communities on the other hand.

In addition, decision-makers must understand that health policy must not be based on political considerations, at the expense of technical considerations for system development, if the health zones are to be sustainable.

1. Introduction

In the spirit of the Alma Ata International Conference on Primary Health Care (1978), the Lusaka Conference (1981), the Harare Conference (1987), and the Bamako Initiative (1987), Benin carried out reforms in an attempt to improve the organization of its health system. Thus, in January 1995, the first Health Sector Roundtable was held. This event was dedicated to the concept of a national policy and strategies that, on the one hand, aimed to upgrade the quality and accessibility of health care and health services and, on the other hand, to strengthen community participation.

To achieve these goals, a program to reorganize the base of the health pyramid was designed for the period 1997-2001. The implementation of this reform resulted in the establishment of health zones according to a process that comprised several activities. These activities included establishing a Support Unit for Health Zone Development (*Cellule d'Appui au Développement des Zones Sanitaires*, CADZS) as well as writing and adopting appropriate laws and regulations, organizing sensitization sessions for political/administrative authorities and local social players, and performing studies to determine the boundaries of health zones, etc.

Prior to these health-specific reforms, in February 1990 the *Conférence Nationale des Forces Vives*, which marked a major turning point in Benin's history, affirmed the country's broader effort to decentralize the territorial government.

In this spirit, Articles 150 and 151 of the December 1990 Constitution confirmed the principles of local authority and its unrestricted administration via elected councils.

Further, in compliance with the policy set forth by the *Conférence des Forces Vives*, the Estates General of the Reform of Territorial Government met in January 1993. Its recommendation for having a single level of deconcentration, the department, and a single level of centralization, the commune, was approved by the Council of Ministers in February 1993.

A monitoring committee was given the task of preparing the laws and regulations. It developed five bills that the Council of Ministers approved and the National Assembly enacted. They were:

- Law n° 97-028 of January 15, 1999, on the organization of territorial government in the Republic of Benin;
- Law n° 97-029 of January 15, 1999, on the organization of communes in the Republic of Benin;
- Law n° 98-005 of January 15, 1999, on the organization of communes with special status;
- Law n° 98-006 of March 9, 2000, on the communal and municipal electoral system in the Republic of Benin;
- Law n° 98-007 of January 15, 1999, on the financial system for communes in the Republic of Benin.

Territorial government reform included transferring a certain number of health-related powers to the communes. This new decentralized body also was given power to implement development projects. For both these reasons, it has become urgent to address the development of health zones and the future of co-management as part of the issue of implementing territorial reform.

It is important to explain the communes' powers—explicit or implicit—in the field of health in order to announce the probable consequences of the reform for territorial government on the zone system. Reviewing the mechanisms stipulated by the law for exercising these powers will gauge their reliability. In return, the review will ensure that the institutional framework that has been established provides the minimum guarantees necessary for the proper management of health activities.

Co-management, which today is a pillar of the health system, must be examined in the context of the new laws. The study of modalities by which it would be possible for new bodies to be more representative should also be analyzed.

This study seeks to contribute to the collective effort to make territorial government reform consistent with health reform.

This is particularly necessary since the process of establishing the health zones is not yet complete. Actually, more than two-thirds of the 33 planned health zones do not yet actually exist, and the process of establishing these operational entities depends greatly on the commitments of the development partners to fund the system’s operation. Thus, the decentralization laws that have been voted are critical to Benin’s health system. For this reason, it is legitimate to express concerns over the future of the health zones in the context of the institutional framework that the reform of territorial government will generate.

2. Study Objectives

2.1 General objective

Make the decentralization of the territorial government consistent with the reform of the base of the health pyramid into health zones.

2.2 Specific objectives

1. Propose procedures for monitoring the operation of the health services and service providers by community representatives;

2. Identify management and decision-making mechanisms for the day-to-day operation of the system. This includes resource allocation, budget allocation, ordering supplies and equipment, and managing maintenance programs;

3. In the health zone, identify the procedures and means for coordination between the organizations (policies and activities of the various establishments that provide health care and service providers, etc); and

4. Make recommendations for carrying out joint and communication activities with the other sectors at the commune and health zone level, raising funds to cover the cost of health services, and exercising responsibilities for certain aspects of environmental sanitation. These should include the supply of clean water and the removal of excreta, participation in local health planning projects, and providing labor and materials for building dispensaries, birthing centers (communal health center, *Complexe communal de santé* or CCS), and housing for personnel.

3. Methodological Approach

With its varied scope, the process of implementing the study brings into play realities that are sociological as well as economic, political, and institutional. This is demanded by the fact that the main issue is the emergence of a new type of socioeconomic organization that seeks to implement a structured interface between decentralization and the reorganization of the base of the health pyramid. The complexity of this subject has led the Ministry of Public Health, which commissioned the study, to select a multidisciplinary approach. The study team is comprised of:

- an institutional development expert;
- a health services manager; and
- a social anthropologist.

The study's geographical coverage encompasses Benin's three geographic regions: South, Center, and North. The following health zones in the regions were visited:

- In the South, the Pobè-Adja Ouèrè-Kétou zone in Ouémé Department and the Cotonou 5 zone in Atlantic Department;
- In the Center, the Savalou-Bantè health zone in Zou Department; and
- In the South, the Natitingou-Toucountouna-Boucoumbé health zone in Atacora Department.

These health zones were selected based not only on their geographic location, but also on their level of functionality as follows:

- a relatively functional health zone, one of the oldest (Natitingou-Toucoutouna-Boucoumbé);
- a health zone that functions relatively well (Savalou-Bantè);
- a health zone that functions poorly (Pobè-Adja Ouèrè-Kétou); and
- a non-functional health zone (Cotonou 5).

The survey population is rather diverse, comprised of players involved in reforming the territorial government or in implementing health reform at the different levels. In each health zone surveyed, the team met with, among others, the following officials:

- The prefect;
- The appropriate sub-prefect or sub-prefects;
- The Director of the Department of Public Health (*Directeur départemental de la santé publique*, DDSP);

- One or more mayors of the current commune;
- The coordinating physician for the zone;
- Members of the health committee;
- The director of the zone hospital; and
- Sub-prefecture health committee (COGES) and/or commune health committee (COGEC) members.

Meetings were also held with institutions and resource persons. These included the National Assembly, the Economic and Social Council, development partners, the Regional Action Center for Rural Development (*Centre d'action régionale de développement rural*, CARDER), development associations, the Municipal Association of Environmental Projects (*Association municipale d'actions environnementales*, AMAE), private and/or religious health centers, the Decentralization Mission, the *Maison des Collectivités*, etc.

Data were collected primarily using meeting guides. Several semi-directive face-to-face meetings were held, and the data were recorded by taking notes of everything that happened as opposed to taking selective notes only.

4. Health Zones, Co-management and Decentralization of Territorial Government: Background and Basics

4.1 Health zones: background and principles

Following the adoption of the primary health care strategy in Alma Ata, the analysis begun at the Lusaka Conference and continued at the Harare Conference resulted in the recommendation to have each country set up operational entities, known as districts, for implementing primary health care. They were to have considerable autonomy in the planning and management of activities at the peripheral level. The reforms undertaken in Benin since 1993 are within this framework. These include refocusing the health policy through the Health Sector Roundtable held in Cotonou on January 12-13, 1995, and identifying the National Policies and Strategies for Health Sector Development (1997-2001), in which the reorganization of the peripheral level of the health pyramid occupies a prominent position.

Dissension very quickly arose over the name, approach, and eligibility criteria related to reform. The Pahou clarification workshop, arranged to pool ideas, culminated in a conceptual and organizational consensus. Benin was initially subdivided geographically into districts, which today are called sub-prefectures. Because the health areas assigned to these districts were not contiguous with the boundaries of the district (to the extent possible, the health zones were to observe the boundaries of the sub-prefectures, although they could combine several health zones into one single zone), it was necessary to find another name that would reflect the same political, legal, sociological, and economic realities as the health district. Hence, the name “health zone” (HZ) was selected to replace “health district,” as adopted by the WHO. In the reorganization of the base of the pyramid, 33 health zones were set up.

Structurally speaking, a health zone combines a set of peripheral services (CCS; village health units or *Unités villageoises de santé*, UVS; and sub-prefecture health centers, CSSP). The zone hospital is the referral level for all of the above.

The operation of the health zones is governed by the principles relative to the objective of Health for All, defined at the Alma Ata Conference:

> Universal coverage for the population with care that meets the needs;

> Services based on promotion, prevention, treatment, and rehabilitation;

> Efficient, culturally acceptable services that are financially affordable and easy to manage;

> Community participation in the development of services in order to encourage self-responsibility and decrease dependency; and

> Including other development sectors in approaches to health.

These principles show how important it is for the operation and management of the health centers to be based on local government mobilization and participation of local authorities in an effort to have them achieve self-responsibility.

4.2 Co-management: background and status

In the operational approach of the health zones, co-management emerged as a form of institutionalizing community participation, one of Alma-Ata's principles of primary health care.

In 1987, the Bamako Initiative galvanized the advent of a cost recovery system and made the community the very basis of the primary health care financing system.

Benin was on the front line of this field, mainly with the Pahou Health Development Project (*Projet de Développement de la Santé de Pahou*, PDSP). This became the Regional Center for the Development of Health Services (*Centre Régional de Développement des Services de Santé*, CREDESA) in 1989. Experiments with bilateral cooperation projects, such as the Benin-Germany Primary Health Care Project (*Projet Bénino-Allemand des Soins de Santé Primaires*, PBA/SSP) to organize community-based structures, recover costs, and promote the active participation of the people in managing health services, are also part of this framework.

Thus, with the decrees of January 7, 1988 and November 18, 1988 on the modalities for public pricing of drugs and pharmaceuticals, all the health units in Benin were authorized to sell essential drugs and keep the revenue for themselves, meanwhile involving the people in the financial management process. This was the beginning of "community financing."

Beginning in 1990, new laws and regulations, (primarily Decree 90-346 of November 14, 1990) gave more extensive powers to the management committees, whose bylaws were adopted and limited the powers of health unit officials.

However, the different laws and regulations that created these management committees do not fully specify the responsibilities and powers of the people's representatives or their relations with health workers. There are still operating problems that are explained by the fact that the management committees do not understand or enforce the laws and regulations. These committees do not always have the technical skills required to play the "role of health center management inspector."

Many other health center co-management issues will be addressed in detail on the following pages.

4.3 Principles of territorial government reform

The passage of the five laws enumerated in the introduction marked the adoption of a three-pronged territorial reform: territorial boundary drawing, administrative deconcentration, and decentralization.

The reform makes the department the sole level of deconcentration and the commune the sole level of decentralization. An elected body governs the communities and a distinction is made between ordinary law communities and communities with special status. A distinction is also made between the powers the communes have in their own right and those that the State delegates to them. The communes' financial autonomy is ensured by the fact that they have their own budget. The role of

administrative supervision is affirmed, as is the State's obligation to support decentralized local authorities and the requirement to organize intercommunal solidarity and provide for local development.

Territorial boundary drawing increased the number of departments from six to twelve. The department is the only level at which the State is represented. Boundary drawing should enable the State to do a better job of national planning and strengthen its land use planning policy.

Administrative deconcentration entails a transfer of responsibilities and powers from the central level of the State to one or more peripheral levels, over which it exercises supervisory power and from which the peripheral levels take their legitimacy. The prefect, who represents the government and the different individual ministries, is the repository of the State's authority at the department level, which is the only level of deconcentration. The prefect coordinates the deconcentrated services and is assisted in this task by directors and heads of services. The prefect exercises supervisory authority over the communes; this involves providing assistance, advice, and legality reviews.

Decentralization is the devolution by the State of responsibilities and powers to territorial authorities that have a legal status that gives them their own identity. This legal status is based in part on the legitimacy their bodies have received through universal suffrage on the one hand. It is also based on the fact that they have financial autonomy that gives them a budget, and they recover their revenue and freely spend their funds in compliance with the laws and regulations.

Reform has created a single decentralization level, the commune, which is administered by an elected council that in turn elects a mayor and a head of community administration, and his/her assistants. The communes replace the 77 sub-prefectures and urban districts. They are divided into *arrondissements*, villages, and city neighborhoods. These intracommunal bodies have no legal status or financial autonomy.

The communes have been given powers in local development, planning, housing and city planning, infrastructure, materials supply and transportation, environment, health and well-being, maternal and primary education, literacy and adult education, health and social and cultural programs, commercial services, and economic investments.

All of the above demonstrates that the reform of territorial government has many of the features that will affect the health system, both in terms of its organization and operation.

5. Problems Related to the Development of the Health System at the Peripheral Level

The purpose of the program to reorganize the base of the health pyramid into zones is so that the workers and the community properly assume responsibility for health care and activities. The choice of this model for operating the system generates certain organizational and management issues.

5.1 Issues related to the health zone

In the context of this study, and without attempting to assess the implementation of the health zones and co-management, the study team considered it necessary to list the main issues. Thus, the discussions held with the different players in the health zones visited made it possible to identify issues in the following areas:

5.1.1 Infrastructure and equipment

The infrastructure and equipment needed to provide proper patient care at every level (CCS, CSSP, and HZ) are still being developed. Despite the State's effort through MOPH programs, several health centers have not yet been rehabilitated to bring them into compliance with the official and other standards. Such is the case of the Pobè-Adja Ouèrè-Kétou health zone in Ouémé department. It should be noted that in health zones not yet assisted by a partner, the funding for building the appropriate infrastructure and equipment is still unresolved.

5.1.2 Human resources

The insufficiency and uneven distribution of human resources seriously limits the implementation of health system reform in the health zones. In fact, the personnel needed to develop the health zones is sadly lacking. For example, for an estimated population of 230,000 in the Pobè-Adja Ouèrè-Kétou health zone, there are only five physicians, including the coordinating physician. This amounts to one physician per 46,000 inhabitants.

The Kétou CSSP, which serves seven commune health centers, has no physician. The Pobè zone hospital lacks the qualified personnel needed to take care of the cases referred to it. Some health centers are still run by inadequately skilled employees, such as a birthing center that is being run by a health care aide.

In the Savalou-Bantè health zone, there are not enough anesthesia nurses, and the only surgeon in the zone hospital must travel periodically to the Banté CSSP in order to perform surgical operations there.

This personnel shortfall is particularly serious in the North of the country, where the mission noted that there is a need to hire roughly 46 new employees in every category in the Natitingou-

Toucountouna-Boukoumbé health zone. Generally, health workers assigned to health units in the North do not stay there and prefer to return to the South.

This shortage of skilled workers is exacerbated by the State's decision in 1987 to freeze the hiring of civil servants in an effort to balance macroeconomic aggregates.

5.1.3 The CSSPs in the health zone system

Very early on, the establishment of the health zones made it necessary to address the issue of the role sub-prefecture health centers play in the new system arrangement.

In some health zones, such as Natitingou-Toucountouna-Boukoumbé, the concept of centralizing zone medical personnel at the hospital level has been adopted to achieve the critical mass of human resources necessary for this referral level to operate. It is based on the principle that, in the current context of the human resources shortage, Benin cannot afford to have underutilized physicians in certain CSSPs, and they cannot perform tasks that are usually performed by nurses.

This decision, which has begun to be implemented in this zone, was rescinded with the intervention of the higher levels of authority, since they considered that having a physician present in each CSSP is a necessity.

However, it should be noted that, in a district or zone system, the referral hospital must have high-quality human resources so that it can play its role correctly. According to primary health care philosophy, the peripheral structures must focus on prevention and basic care activities.

The issue of keeping general practitioners in the CSSPs should be reviewed based on the individual situation of each structure in question. The review should be based on specific criteria such as demography, accessibility, viability, or profitability.

All the specialists (surgeons, gynecologists, etc.), must be located at the zone hospital level. Instead, there still exists the somewhat irrational situation in which some CSSPs nevertheless maintain their surgery units, which could have been transferred to one of the CSSPs that was under consideration to serve as a zone hospital.

The issue of the technical capacity of the CSSPs is a sensitive one, since it is often marked by rivalries between localities, with a backdrop of rather conflicting relations that arose in an often very distant past. One of the threats to the zone system may be the fact that some localities refuse to rely on a zone hospital in a rival locality and that they are unhappy that the other locality has the zone hospital.

It should be underscored that the cohesion of the health zone is an essential requirement for the survival of the zone system, because such a system assumes that there is a common vision and concerted approach under a single authority. That is why the tendencies of certain CSSPs to be autonomous from zone management must be countered, mainly by sensitizing the people and the different stakeholders.

5.1.4 Drug supply and distribution

The fact that there is no drug distribution center in the health zones (except in Natitingou-Toucountouna-Boukoumbé), plus the fact that drugs are frequently out of stock at the Drug Purchasing Clearinghouse (*Centrale d'achat de médicaments*, CAME), seriously threatens health zone operations. The establishment of drug distribution centers would make it possible to distribute drugs at the operational level and to join forces to obtain drugs for the entire zone. This has the advantage of maintaining stronger links between the members of the health zone management team and the different peripheral structures. This procedure also provides the decision makers (coordinators, head physicians, hospital managers, and heads of health units) with better information on drug availability in order to prevent drugs from being out of stock.

In addition, as in the case of Natitingou-Toucountouna-Boukoumbé, the funding of health zones by rebates from structures could be replaced by establishing a profit margin for health zone funds.

It should be noted that generic drugs will soon be available in the private center market. They will compete with the CAME.

5.1.5 Management and evaluation

The provisions of Article 14 of Decree N°98-300 of July 20, 1998 on the reorganization of the heath pyramid's base, according to which the health zone is given legal status and management autonomy, are not observed in practice.

In practice, the State's financial contribution is managed directly at the DDSP level, and the zones are often not informed of the exact amount allocated to them. It is urgent to deploy these funds to the health zones, whose authority and management capabilities are growing. The coordinating physician and the zone management team should be the managers or administrators of these funds instead of the DDSPs, which should be limited to an audit function

5.1.6 Village health units

The village health units (UVS) are run by village health committees. They were designed to be instruments that mobilize communities so that the population assumes responsibility for health issues at the most peripheral level, around trained birth attendants and community health workers. However, in nearly every case, the UVSs do not work because the communities have, among other things, difficulties instilling a minimum level of physical and financial motivation in the community workers. If the important role the UVSs must play in mobilizing village communities on health issues is acknowledged, it is understood that there is an urgent need to revitalize them with the perspective of sustaining their programs. Foremost, it is important to make the village women's groups and associations highly accountable for UVS management, without neglecting co-ed associations when they have potential and dynamics that can be of use.

Next, the UVSs' activities should be integrated into other development activities, again, particularly those carried out by women's groups and associations. This would make it possible to arrive at a situation in which motivating community workers could in part be supported by resources from a revenue-generating collective activity. For example, in the operation of a mill, it would be possible for a group of women to consider obtaining resources to support health care activities. Obviously, this will not be possible unless the different sectors involved in development support truly

collaborate at the base, both in the planning and implementation of activities. Hence, if the need to have a functional UVS unit is expressed at the same time as the need for having a mill, then the mill, made available to the women by the deconcentrated services and projects of the Ministry of the Status of Women, could partially support the UVS in the context of an approach that the group freely accepts. Implementation would be supported by the deconcentrated services of the two ministries (Health and Women). Making the group accountable for UVS management would be highly legitimized as a result.

5.1.7 Intersectoral collaboration

Intersectoral cooperation, which is one of the principles of the primary health care strategy, has merit in that, through collaboration with other sectors, it solves problems that have an impact on health issues but that the health sector cannot solve on its own.

The areas listed in this study's terms of reference, namely hygiene and sanitation, social communication, clean water supply, and infrastructure planning and construction, involve sectors as diverse as the Environment, Water, the Status of Women, Information and Communication, the Plan, Rural Development, Literacy and the Interior.

Unfortunately, this study found that intersectoral collaboration is almost non-existent. The different officials stated that they were willing to work with others. However, without an institutional framework for collaboration, it is obvious that intersectoral collaboration will continue to be a slogan without content.

The Savalou example shows the importance of such an institutional framework. In fact, a non-governmental organization (NGO), the Municipal Association of Environmental Projects (AMAE), provided the impetus for implementing a municipal environmental action plan whose design involved the representatives of the deconcentrated services concerned, the development association, and the people, all working around the sub-prefect. A steering committee, chaired by the sub-prefect and including all the players, meets regularly to direct and monitor the activities. These activities include building public and private latrines, collecting garbage and controlling illegal garbage dumps, and creating a hygiene brigade of 40 youths led by the hygiene worker from the health center, who is responsible for enforcing the Hygiene Code. Funding for the "trash pickup" line item in the sub-prefecture's budget is allocated to these activities, which receive support from several development partners through the Ministry of the Environment.

The adoption of an Intersectoral Action Plan is a powerful collaboration and monitoring instrument. It strengthens the synergy between complementary sectors, which, in nearly every case, are unfamiliar with each other. When several sectors rally around an integrated local development plan designed in cooperation with the communities, incorporating the expectations of each sector and implementing complementary resource utilization, there is reason to believe that tangible results can be achieved. Conversely, with no coordination framework or integrated plan, intersectoral collaboration results in disjointed initiatives, often the work of highly generous officials in terms of effort, but based on personal affinities and lacking any solid institutional foundation.

Thus, intersectoral collaboration raises the issue of the program coordination body and the plan as the instrument.

In Natitingou, the plan's importance as an intersectoral collaboration instrument caused the study team to become interested in the experiment of the Regional Action Center for Rural Development,

which is part of the Rural Development Ministry. In Atacora and other departments, CARDER implements the village-level participatory approach (*Approche Participative de Niveau Village*, APNV). With CARDER's technical support, this approach allows communities to survey their needs and design local development plans involving every development sector. For example, it should be noted that the finding that the UVSs are not working often arose from this exercise, and that health issues are in a prominent position.

Unfortunately, the APNV experiment, at least in Atacora, suffers from a lack of involvement of the other sectors. The deconcentrated services of the other sectors are not involved; consequently, the issues the people have raised cannot be taken into consideration by these services. If the CCS nurse or another health worker were present, a better job could have been done of explaining the different planning stages to the community. This would be the way to better integrate their plans into health zone programs.

Collaboration also permits experience-sharing among the different sectors. For example the construction of village storage centers by the communities, with aid from the CARDER, is an experience to be shared. The CARDER financing was bolstered by the involvement of communities that provided labor and local materials. This is the mark of a rather strong commitment. Such an approach could be adopted to build health infrastructure, engendering in the communities the feeling of ownership of the health facility. This ownership will lead them to pay closer attention to maintaining and managing the health facility, and to developing the activities that take place there.

Decentralization provides opportunities for intersectoral collaboration which will be addressed later.

5.2 Co-management issues:

Community participation in the health effort takes place through management bodies known as COGECs in the current communes (future *arrondissements*) and COGESs in the current sub-prefectures (future communes).

The members of these units work alongside health professionals to promote health in their area of responsibility and to manage health unit resources.

The health committee, a body that represents the health zones, strengthens the institutional framework of community participation.

In the context of examining the reorganization of the health pyramid base in terms of co-management, the following issues have been identified:

1. The co-management regulations currently in effect are unsatisfactory and raise serious collaboration problems between health workers and management committee members.

Institutionally speaking, the same co-management committee (COGEC or COGES) decides as well as executes, whereas the exercise of these two powers should be separated. Likewise, some of the provisions of Decision n° 1269 on the powers, composition, organization, and operation of the health zone committees are not sufficiently clear. The study will return to this in detail (see section 8.2, on health committees).

2. The future of COGES members of CSSPs converted to zone hospitals is problematic because, in this case, the COGES has no home structure.

Similar to the experiment in progress in the Savalou-Bantè health zone, a first-contact health center should be set up in the same town as the zone hospital. Thus, the former management committee would find in that a framework for expression, leaving it up to the health committee to deal with the zone hospital as the regulations stipulate. Meanwhile, it should be noted that the creation of this new center has the benefit of regulating the patient referral circuit because, in this case, the zone hospital would see only cases that are referred, in accordance with its mission.

3. Conflicts arise from insufficient information and communication. Moreover, there are gaps in the existing laws between health workers and management committee members. Therefore, health workers are often frustrated by the control exercised by COGEC and COGES members, because they consider them suspicious. The community representatives sometimes conceive of their role in a way that causes them to believe that their prerogatives include supervisory power over health workers.

4. The employees' needs for more financial motivation and the tendency of community-level elected officials to refuse to do volunteer work pave the way for placing what may be too much pressure on community participation resources.

5. Relations between the health workers and elected community officials are moving away from community participation objectives and are crystallizing around fund and drug management.

6. The Health System Being Tested by a New Territorial Boundary Drawing

The implications of territorial government reform on the health system are greater and more obvious under decentralization. This is because the communes have received authority over health care services and because they play a substantial role in coordinating and implementing development activities. This explains that the impacts of territorial boundary drawing and deconcentration did not spontaneously emerge in the concerns of the persons that the study team met, contrary to the impacts of decentralization.

However, by creating six more departments for territorial boundary drawing, reform has introduced in the health sector the debate on the matter of possibly setting up six new DDSPs and the construction of six new department hospital centers.

6.1 Territorial boundary drawing and the creation of new DDSPs

Once their attention is drawn to the matter of setting up new DDSPs, most of the people contacted by the team deemed it understandable that each new department would have a DDSP for coordinating health programs. This was true notwithstanding the considerable human and financial resources this would involve, so that health program coordination would be evenly implemented in all administrative districts.

However, this viewpoint was disputed by those who thought it impractical to set up new DDSPs which, in some cases, would only have two health zones to supervise. They feel that the necessity of having high-quality human resources for the DDSPs and technical support for the zones makes the creation of new DDSPs dangerous. The reason for this is that doing so could contribute to scattering the few resources that exist, or could even cause human resources to be drained at the peripheral level.

Addressing this issue should not obscure the fact that DDSPs are a deconcentrated service of the State, and they must play a specific role with the prefect. The consideration that the current DDSPs would be in charge of managing two departments means that half the prefects would have no health advisors and no authority over the departmental team in charge of coordinating and controlling health service activities in their administrative district.

Besides, the fact that a DDSP has only two or three health zones under its authority could make more sustained cooperation and more synergies possible between the DDSP and health zones.

The human resources required for the new DDSPs to operate should be provided by the central level and currently existing DDSPs, but it would be dangerous to take them from the peripheral level, as this would increase the tenuousness of the health zones.

6.2 Territorial boundary drawing and the construction of new department hospital centers

Although the previous issue was subject to differing points of view, nearly everyone agreed that the new department hospital centers (CHD) should not be built.

The people questioned feel that it would be a serious mistake to build new CHDs. They noted that the manner in which the referral system is organized does not obey the logic of territorial boundary drawing; the health zones are proof of that. This viewpoint was expressed many times, especially since it takes into account the considerable resources that such an investment would require, at a time when the priority should be to find the resources necessary for all the country's health zones to operate.

The alternative, which would involve converting the hospital in the new department seat into a CHD, would interfere considerably with the referral system and should in no case be adopted as a satisfactory compromise between "political" and "technical" considerations, since the former would overwhelm the latter.

In the opinion of the study team, there is nothing to prevent the Ouémé CHD, for example, from continuing to play the role of referral structure for zone hospitals and of the CSSP in the original department of Ouémé, based on the new division into the departments of Ouémé and the Plateau.

However, it should be expected that the people and leaders of the new departments will raise the issue of building a CHD and will very strongly demand it, especially since the absence of a certain type of infrastructure could give credit to the idea of having second zone departments.

An effort to explain this to the people and their leaders should be made so that they understand that their interest lies mainly in strengthening the zones by building zone hospitals, rehabilitating dilapidated infrastructure, obtaining appropriate equipment for the structures, and providing the necessary human resources.

This does not mean that new CHDs should not be built in the future. However, in the current context, it simply means that the priority must be to considerably strengthen the network of peripheral structures. Doing so would also significantly reduce the bottlenecks in the CHDs, which have everything to gain from an efficient implementation of the primary health care strategy.

7. Principles and Mechanisms for Exercising Power Transferred to the Communes

7.1 The powers of the communes in the health sector

Among the many powers transferred to the communes is the responsibility of building, equipping, repairing, and maintaining the public health centers at the level of the *arrondissement*, village, or town neighborhood. The State is to transfer the resources required to properly carry out these powers under Article 100 of Law 97-029 of January 15, 1999. The structures affected are the existing communal health centers, dispensaries, and birthing centers at the communal level and village health units.

Not included under the powers of the commune are all other structures: sub-prefecture health centers, urban district health centers, health zone hospitals, CHDs, the national university hospital center, and private and religious structures. It should be noted that the law does not give the commune any powers to manage any health structures, even at the *arrondissement*, village, and town neighborhood levels.

This finding is in no way ambiguous; in fact, it is stipulated very explicitly in the sectors in which lawmakers give the communes management powers. For example, this is the case for bus stations, pier buildings and local parking structures (Article 89 of Law 97-029) and for markets and slaughterhouses (Article 104 of Law 97-29). Nevertheless, most of the apprehensions expressed by study interviewees are based on the fact that they (wrongly) believe that the communes will have power to manage the health structures.

Still, it is important to note that even if the commune has not received any management powers, a problem will arise for structures it develops using its own funds or through decentralized cooperation. If a commune builds a structure and assigns it to the State, no problem arises. Conversely, the commune would rightly consider that the structure it builds is an integral part of its assets. In this latter case, a management system should be identified that takes into account the fact that the structure belongs to an institution other than the State. Besides, the matter of religious hospitals that are to become zone hospitals raises an issue that is no less complex, but for which solutions are now being devised.

The review of the communes' power shows that they have no authority over health workers. This should reassure certain health workers who fear that the reform would place them under the authority of mayors.

Moreover, the assignment of employees to the health structures by the future communes needs to be made formal. The problem under the current system is that the sub-prefects assign some of their workers to health structures and then take them back, even though the structure has not had the time to prepare for this new deal. In order to avoid these problems, such "loans" of employees should be the subject of an agreement between the commune and the health committee. The agreement should

include specific provisions on the terms of renouncing the agreement and the period covered by the assignment of the employees.

Furthermore, the people surveyed by this study strongly expressed the fear that inappropriate commune policies would interfere with the implementation of health activities. But, here again, the law sets up safeguards by requiring the communes to exercise their powers in accordance with the sector strategies, regulations, and national standards (Article 108 of Law 97-029). This prevents the commune from having to question the thrusts of health policy or from implementing programs that contradict the strategies identified in the health sector.

Furthermore, the supervisory authority of the prefect should harmonize the communes' policies with national policies. This is addressed in Article 142 of Law 97-029 and Article 84 of Law 97-029, particularly in terms of preparing and adopting its development plan.

The fact that the communes have been given power over planning gives them a prime role in developing intersectoral collaboration. In principle, the commune development plan is adopted after the various deconcentrated units have given their approval. The plan should be used as an instrument of intersectoral collaboration that fosters effective and efficient resource utilization.

With regard to environmental, hygiene, and well-being issues, communes receive broad powers for supplying and distributing drinking water, collecting all types of garbage, sanitation, food hygiene, controlling carriers of contagious diseases, etc. (Articles 93 and 95 of Law 97-029). In addition, they prepare the regulations on individual sanitation (latrines, sumps, and septic tanks) according to Article 95 of Law 97-029. It will be in the communes' interest to have the different sectors become involved in these areas using a concerted and complementary approach.

Based on the Savalou experiment, the communes could also foster community initiatives for self-responsibility in matters of hygiene and the environment by giving them all the support they need.

The health committee should encourage mayors to establish intersector coordination frameworks that call for assuming the powers of communes in hygiene, the environment, and sanitation.

7.2 Managing transferred resources

It is important to draw the attention of the health players to the provisions the lawmakers have introduced to ensure the orthodox management of the commune's resources, and especially transferred resources.

These provisions should help allay fears expressed by study respondents that mayors could divert the funds allocated to health and use them for political or personal purposes, or to pay the commune's other expenses.

The resources that are linked to the transfer of power are listed as investment revenue, proceeds from subsidies, or investment and equipment allowances given by the State (Article 15 of Law 98-007 on financial treatment for communes). As for any budget revenue, the resources must be listed in the books kept by the commune's accountant, unless the Minister of Finance grants a waiver under Article 35 of Law 98-007.

At the commune level, the duties of the commune's appropriator of funds and its accountant are separate under Article 34 of Law 98-007. Thus, the mayor appropriates funds for the expenses; the Minister of Finance appoints an accountant from the Treasury to be the commune's accountant. The accountant is both the receiver and collector for the commune and the mayor's advisor. The commune's accountant should audit the commune accounts and may suspend payment for improper spending. He is even permitted to refuse to comply with a requisition from the mayor if the request pertains to expenses using funds that were improperly appropriated, funds other than those that the spending was intended for, or failure to provide a service according to Article 48 of Law 98-007.

It should be added that the transferred funds are allocated to the investment expenses section. For these, transfers of funds from item to item or from a chapter fall under commune council's purview. The supervisory authority must approve them according to Article 38 of Law 98-007, as opposed to operating expenses, for which the mayor may make transfers from item to item, within one and the same section. The mayor must also report this to the supervisory authority and the council. This means, for example, that the mayor may not decide to use the funds to repair a birthing center or build a classroom.

Moreover, for spending, the mayor makes the commitment to pay, settles, and pays according to Article 44 of Law 98-007. He is required to report to the prefect on a quarterly basis his accounting, as well as the expenses he has incurred according to Article 44 of Law 98-007. For health expenses, since the prefect could require clarifications from the DDSP, it is advisable for the DDSP to be periodically informed by the coordinating zone physician of any problems related to the transferred powers. This is done so that, using his privileged position as the advisor to the supervisory authority, he can make suitable decisions, in particular to protect the health structures from any potential abuse by the communes.

Interview subjects expressed serious reservations about the lack of congruity between borders of health zones and other territorial subdivisions. As noted earlier, nearly all the zone coverage areas encompass the territory of several communes. Interviewees fear power conflicts between mayors or difficulties in making the integrated health activities consistent in the health zone.

This study finds that this fear is unjustified because it is based on the idea that the different communes in the health zone have power over the zone hospital, and even over the zone itself and that, for this reason, they may overlap. Even the use of the principle of intercommunality is unnecessary here, because no structures are to be jointly managed. Moreover, the establishment of the health committee, of which the mayors are members in the same right as the community representatives, the State, and other institutions, may be the framework for joint action and the harmonization of the various interventions.

There also are cases, such as Cotonou, where a commune covers the territory of several health zones. In this case, coordinating physicians will not have to deal with several mayors at the same time. Furthermore, the DDSP's activity will be facilitated by the existence of a territorial authority that works with several neighboring health zones using approaches that will probably not be contradictory.

7.3 Mechanisms for transferring and utilizing delegated funds

The State's contribution to health zone operations, now managed by the DDSP and paid for by the funds of the department's receiver of finances, must be transferred to the zone in order to comply with the principle of management decentralization. Since the funds must be kept in the public

treasury, they will be in the funds of the receiver of finances at the department level or in those of the receiver-collector in the commune where the zone hospital is located.

In the first case, the prefect would be the fiscal officer and the receiver of finances would be the accountant, while the coordinating physician would administer the funds. In this situation, the health committee could determine how to allocate resources and make the zone physician and permanent delegate responsible for initiating the process of purchasing the materials needed. Toward this end, they would select vendors in conjunction with the health committee's secretary as well as the health zone's manager. After the administrative phase of the ordering process, carried out by the prefecture, the suppliers would deliver the items to a receiving committee comprising health committee members other than those who placed the order.

If the funds are kept with the receiver-collector's funds of the commune where the zone coordination office is located, the mayor of that commune would be the fiscal officer for funds to be used in an area that encompasses the territory of the neighboring communes. According to Article 7 of Law 98-007, these funds could be allocated to a special budget. Since all the mayors of the communes covered by the health zone are members of the zone's health committee, this body could order the permanent delegate and the coordinating zone physician to send the mayor of the commune a list of needs along with a record that they would co-sign. They would do so after deciding how to allocate the funds.

After checking the order forms for compliance with the health committee's decisions, the mayor would sign the forms and then forward them to the suppliers. After receiving the supplies ordered, the health zone would send the mayor the invoices and delivery receipts with the notice of receipt for liquidation and payment by the receiver collector. This procedure assumes that the finance ministry first appoints this commune's accountant as the recipient of funds delegated by the health zone in question.

Of these two possibilities, the first seems more realistic since the prefect–the fiscal officer–has a position that gives him authority over all the communes involved.

The resources for the transferred powers are managed differently because they are for construction, obtaining equipment, repairing and maintaining the structures at the *arrondissement* level. They are to be transferred to the different communes that will record them in their budget as investment income.

The funds that communes receive from the State for building and equipping the health structures must be allocated according to the needs the health zone expresses through its planning. It must be strongly emphasized that no individuals, groups of individuals, or institutions, including the commune, should be authorized to build or provide equipment for health infrastructure without obtaining the approval of the zone health committee. In the current context of a shortage of resources, it is obvious that a zone management committee will not oppose an investment unless it causes more problems than it solves.

The commune could build and outfit health structures and carry out "heavy" repair work according to standard procedures for any project of this type. Standards should be identified to define "heavy" repairs. However, for any construction, outfitting, or "heavy" repairs, stipulations should be made for the health committee to submit its opinion of the technical aspects in a written report from the coordinating zone physician. For example, the report should address the compliance of the construction plans with standards for health structures or the quality of medical equipment. The health committee's opinion should not be a constraint for the commune. However, if the health committee

considers that failure to take its opinion into account could result in a serious problem, it should inform the supervisory authority of that opinion in a reasoned letter with a copy to the DDSP. The prefect would then make a decision after having obtained the opinion of all interested parties at the least.

The health committee's opinion on the compliance of the construction and equipment with the standards does not challenge the communes' power for issuing construction permits or for checking the compliance of activities and construction with the rules in effect as indicated in Article 84 of Law 97 –029.

The commune may undertake light repairs simply by advising the manager of the structure in question and the management committee. The manager of the structure and the chairperson of COGEC should sign the certificate of completed work.

If the commune receives resources for maintaining structures, it may enter into a contract with a service provider based on proposals from the COGEC.

The commune could also remit the corresponding funds to the COGEC as a grant since, according to the spirit of Article 55 of Law 98-007, it may give subsidies to associations, agencies, foundations, or businesses. Obtaining a grant requires these organizations to be audited.

The provisions of Article 108 of Law 97-029 give the commune the opportunity to delegate the performance of a certain number of projects to various organizations, associations, and institutions. The COGECs may therefore be placed in charge of maintenance and light repairs.

The mayor awards the commune's contracts after obtaining the approval of a commune bid evaluation committee which may include qualified people other than the commune councilors (Article 126 of Law 97 – 029). Consequently, for health-related contracts, it is advisable for the mayor to ask the chairperson or permanent delegate of the health committee, the coordinating zone physician, and the head of the CSSP to serve on the committee. Involving zone officials in a project limited to the commune's territory prevents questions arising at the commune level from being settled solely by the mayor and head physician of the CSSP. Given the institutional fragility of the zone system, it would be dangerous to risk that the territory of each commune would become a micro-health zone in which the mayor and CSSP physician would work independently of the zone.

8. Co-management in the Context of Decentralization

8.1 Management committees

The matter of the relationship between the future elected officials and the co-management bodies, or of their potential involvement in co-management, has been a major issue expressed by the different players. The fears noted at this level pertain primarily to the likelihood that they may take the place of the members of the officials of the COGECs and COGESs, either by removing them from co-management after having denied them any legitimacy, or by confining them to roles of second-zone players.

Decentralization introduces the debate over keeping the community's current representatives in the co-management bodies once mayors are elected by popular vote with greater legitimacy.

In this study's opinion, it would not be prudent to relieve the current COGEC and COGES members of their duties. Instead, the existing method of community representation should be maintained, and it should be improved. The mayor's representatives should also be included.

The COGECs should break from the status quo since, in most cases, only residents of the locality where the health structure is located can be part of the co-management body. For example, in each village served by the CCS, one youth representative should be elected, one representative of women, and one representative of men. The elected officials of the different villages would meet to elect three youth representatives, three representatives of women, and three representatives of men who would be COGEC members. In addition to these nine members, there would also be two representatives of the mayor, including the *arrondissement* council chairperson. These people would not be eligible for serving as COGEC president, secretary or treasurer. Care should be taken to ensure that people who reside in the locality where the structure is located assume the responsibilities that require a constant presence. The three elected representatives in each village would be support points for the health promotion activities that COGEC would carry out.

The current composition of the COGESs, composed of COGEC representatives, could be maintained, with two communal councilors that represent the mayor in addition to the others.

The presence of the mayor's representatives at the lower co-management levels is justified by the fact that the mayor needs to be informed of the issues that arise at this level in order to correctly play his role on the health committee, which is the higher co-management body.

The concerns that some study contacts expressed about the fact that community participation resources could be budgeted by the commune are unjustified, since there are no laws or regulations that give the commune any power whatsoever over community participation funds.

8.2 Health committee

Health committees were established by Order 1269/MSP/DC/SGM/CADZ. This measure is a remarkable solution that is in anticipation of intercommunality in that it opens this body to mayors of communes located in the health zone. As the zone's supreme representative and decision-making body, it comprises the coordinating zone physician and the zone hospital director (as advisory members) and members with decision-making power as follows:

- the DDSP representative;
- the COGES representative(s);
- the current sub-prefect(s) or future mayor(s);
- two representatives of donors appointed by the donors;
- two representatives of active NGOs appointed by the NGOs;
- one representative of the social private sector appointed by the sector;
- one representative of the professional private sector appointed by the sector; and
- two representatives of elected personnel with one Parent Teachers Association (APE) and one contractor (one from the zone hospital and one from the CCSs).

Due to the above-mentioned problems, *representation could be strengthened* by including the following:

- one additional representative per COGES, so that the lower-level co-management bodies are well represented in the body of the next higher co-management level;
- one representative of the women's associations and groups in each commune so that women are significantly represented and can participate in making health-related decisions; in addition, including women's groups at this high decision-making level will enable them to feel more involved and will be an incentive for them to mobilize their member organizations, especially in health promotion activities;
- the chairperson of the social affairs committee of each commune, since this committee is in charge of health issues, and since it is necessary to involve another elected official besides the mayor and inform him or her of health activities; and
- a representative of CSSP personnel, since the order only mentions CCS and zone hospital representatives.

Augmenting representation may cause some to fear that there will be too many members. However, it should be noted that even if the zone covers four communes, the health committee will never have more than 30 members. This is an acceptable number for a board of directors, especially if the inevitable cases of absenteeism are taken into consideration.

It must be explicitly stipulated that the DDSP representative, the mayor, the chairperson of the commune's social affairs committee, the donor's representatives and the employees' representatives

may not serve as chairperson, permanent delegate, or secretary. In special cases, the employee representatives may serve as secretary. The situation of one health zone in Zou department should be avoided, in which a sub-prefect was elected to chair the health committee. It would also be regrettable if the chairperson of the health committee were a representative of the DDS, a donor, or an employee since, in that capacity, that person would have under their authority the head physician of the zone, who is his supervisor.

Furthermore, the donors' representatives should serve on the health committee only as observers or as members with an advisory vote. In any event, the fact that the donors are members of the health committee with the right to vote is problematic in terms of their mission, which must be limited to support and must not include any decision-making power.

To finalize Article 13 of the order, the *principle of a secret vote* must be adopted for elections in the health committee and for making all important decisions. The idea is to prevent psychological pressure from highly-placed people, such as mayors, from altering the votes or positions of the body's members. Such a situation occurs frequently in bodies with highly diverse member backgrounds, where there are people with very different levels of intellect, social standing, and influence. For example, in electing the chairperson or permanent delegate, if the vote is taken by a show of hands, the representatives of a commune's women's group may vote the same way as her commune's mayor simply because she does not wish to vote against him.

On the subject of *"active" NGOs*, the order obviously seeks to exclude NGOs that exist only on paper. However, since there are no criteria to determine what constitutes an active NGO, there may be conflicts between NGOs that claim to be representative, with each claiming a real presence in the field. To overcome this obstacle, it could be stipulated that, in order to obtain the right to help choose their representative, the different NGOs will have to send the DDSP a detailed report including evidence of the activities they have carried out over the past twelve months. After verification, this would allow the DDSP to make the decision to approve them. Currently, in one zone, the health workers may give the DDSP specific information on the actual activities of each NGO.

The health committee should obtain clear *assignments from the zone hospital's board of directors* because the order is silent on this. For religious hospitals considered zone hospitals, a framework other than board of directors may be adopted that takes their specific features into account.

The terms "social private sector" and "religious hospital" used in the order and in most official documents should be replaced with *"health center for humanitarian purposes."* This would bring them into compliance with the definitions in Article 1 of Law 97-020 of June 17, 1997, which sets the requirements for practicing medical and auxiliary medical professions with private clients.

Article 11 of the order gives the health committee power to manage conflicts. However, it would be more appropriate to stipulate expressly that the health committee has power to *arbitrate conflicts* in the COGESs and COGECs, on the one hand, and between community-elected officials and health workers on the other hand. One of the current problems of co-management is the absence (or non-functionality) of credible conciliation and arbitration bodies. The head physician of the CSSP, the chairperson of the COGES, and the mayor should first explore every means of conciliation for conflicts at the level of the current CCSs. The coordinating zone physician, chairperson of the health committee, and the mayor should do the same for conflicts at the level of the current CSSPs or zone hospital.

The health committee could play a major role in the design, negotiation, and implementation of *decentralized cooperation agreements* in order to avoid certain proceedings. In some African countries where decentralization is already several years old, opportunities for decentralized cooperation are often poorly used because the mayors talk with their counterparts from the countries of the North without considering the needs already identified by the bodies having jurisdiction. The result is either structures that receive equipment above their technical level, or with infrastructure that duplicates existing equipment. However, in both cases the resources used should be assigned to more relevant needs. One reason for the inappropriate match of resources is that mayors often converse with colleagues from the West during international meetings about resources. As experts often do not accompany them, they consequently accept every proposal for support they receive, without being able to determine which one is the most useful for the people they govern. Furthermore, often they do not realize that in some cases it is wasteful to build infrastructure or that equipment is useful only if it fits into the structure's technical level.

The fact that the mayors and chairpersons of the social affairs committees are members of the health committee will enable them to become very familiar with their health zone's and their commune's issues and needs. As a result, even if there is no technician, they will be in a position to attract the relevant inputs to their commune. The health card could be an excellent tool for them, especially since, as health committee members, they are involved in approving the zone's general policy outlines, approving the strategy plan, and approving the zone's annual plan.

The lawmakers made the approval of the supervisory authority a prerequisite for establishing relations with foreign decentralized organizations or for joining an international organization. This strengthens the health committee's position because it would be unthinkable that the supervisory authority could approve establishing decentralized cooperation relations in the area of health without asking for the health committee's and the DDSP's opinion.

Such emphasis on decentralized cooperation seems useful because, lacking their own resources and given few contributions from the States, local authorities in the countries of the South obtain considerable opportunities from decentralized cooperation. These opportunities need to be used efficiently.

The health committee should be installed under the prefect's chairmanship, while the DDSP serves as secretary for the meeting. This does not create too much work for the prefect because the number of zones is limited in each department and the health committee is only installed once in its history. Moreover, the pace of health committee installation is not intense. The prefect's presence would induce the mayors to give this body all the importance it deserves, which would make the prefect feel involved in everything the committee does.

After each health committee meeting, the chair should send the prefect (in care of the DDSP) the written meeting minutes. Involving the supervisory authority, even symbolically, gives the health committee greater institutional visibility and strengthens its credibility. The mayors are therefore less likely to refuse to recognize the zone body's legitimate authority. However, the mayors, with all the powers assigned to them, may not always look favorably on this body on which they serve without chairing it. Another reason for this would be if they do not have a voice that takes precedence over that of the other committee members who, nevertheless, are among the people they govern.

The zone system would be rendered fragile if the health committee does not have considerable support from the supervisory authority and government through the Health Ministry.

9. Toward a New Context: Opportunities and Threats to the Health System

Territorial government reform will have a profound effect on the health system in the coming years. The new institutional framework encompasses major changes that make it necessary to identify in advance both opportunities and prospective threats offered by the new context.

9.1 Opportunities offered to the health system by territorial government reform

Territorial government reform, which is essentially a decentralization reform, reinforces the tendency to transfer powers from the center to the periphery. Moreover, by moving decision-making to the periphery, reform forces all the players to adjust to the decentralization of power, because from this point on, most action will take place at the base.

The political class in Benin, or at least its most significant components—both majority and opposition—support territorial reform. In addition, the current laws, which the second legislative session adopted, were not challenged by the third legislative session. Health and other sectors that will make major institutional changes in order to adjust to the next context may be reassured by this guarantee of permanence because it reduces the risk of having reform challenged by political forces.

Development partners and donors alike support reform and have committed to making a financial and technical contribution to its success. The requirements have been met to initiate programs through which the communes would have an incentive to invest in health. The matching experiment that USAID has implemented in other countries could be part of such a framework. This entails providing financial support for the work of the local authorities who agree to invest their own funds in health activities.

This system is particularly worthwhile in Benin's context in that it would assist in encouraging the communes to situate their programs in the framework the health committee has defined. The health zone's representative body would obviously be fully involved in drawing up and entering into partnership agreements.

The communes can provide the health sector with considerable resources, thanks to decentralized cooperation. The effects of the shortage of State resources will thereby be mitigated.

The commune of the economic capital, Cotonou, will have resources that it will be able to use, just like other large African cities, and may use its own funds to bolster the network of health infrastructure and personnel.

In view of the considerable scope of powers the communes have, these jurisdictions can play the role of catalyst in establishing sustainable intersector cooperative relations.

The mayor could protect the health system's interests, especially by pleading for available personnel for the structures located in his territory. Where the sub-prefect may be hemmed in by

submission to the higher level, the mayor of an underprivileged commune can carry out bold programs with decision makers to cause them to reduce assignments where there is no replacement.

With decentralization, the State could even keep certain budget line items at the commune level to ensure that these items will be filled at all times. In this case, an employee who quits his job will no longer have a budget line item, and that item will remain with the commune. The difference between keeping budget line items and hiring based on jobs is that, in the latter case, the person is still indefinitely attached to the job, whereas in the former, the State continues to apply its assignment and rotation policy for employees with a constraint. That constraint is that each time it assigns someone, it must replace him. This is true because each time an employee is assigned to a locality, he must fill the budget line item of another employee of the same rank who, in turn, must move into another employee's position, and the other employee must move also. Ultimately, the employee who was assigned first must necessarily be replaced in his job.

9.2 Territorial reform and threats to the health system

The fact that the zone system is not yet widespread makes it extremely vulnerable given the prospect of the installation of future communes. If all the health zones are not yet installed when the new local authorities are established, some mayors will be members of the health committee, while others will not be, because the health zone has not been set up. Thus, whereas the former will be forced to develop their programs in the framework defined by the zone, and will have the zone physician as a contact, the latter will have more leeway because they are not bound to any health committee and will have the DDSP as a contact.

This two-speed communal intervention will weaken the zone system because mayors who are health committee members will compare their situation to that of their other colleagues. They will feel as though they are being directed, controlled, and constrained by their health committee, deprived of the relative independence their other colleagues have. By developing these negative feelings about the committee, these mayors may also balk at the idea of having to deal with the coordinating zone physician while their other colleagues have their superior as a contact. The failure of the zone system to be widespread will create an adverse situation in which mayors of communes not covered by a functional zone will have more leeway and more direct access to the higher levels in the department.

With decentralization, there will be very bitter competition to control the communal and municipal councils. Policy contradictions will continue to be heated and may have a negative impact on the commune's activities, particularly in health. On this point, the health sector's vulnerability compared to the other sectors lies in the fact that its operational zone covers several communes whose mayors are health committee members. If radically opposed political forces were to control two communes in the same zone, there would be reason to fear for cohesion inside the zone. On the other hand, in sectors such as education, where the operational level is limited to the territory of a commune, the risks are not nearly as great.

Some CSSP physicians who do not accept the leadership of the coordinating zone physician may develop tendencies toward autonomy with their commune's mayor. Both the mayor and CSSP physician are required to refer matters on health issues to a zone center which identifies the policies and makes the major decisions. The mayor, in the name of the legitimacy he receives through the popular vote, may wish to break away from what may look like supervision, whereas the CSSP physician would take advantage of the mayor's caution to carry out certain programs autonomously and take positions hostile to the zone. This would be particularly true if there are tenacious rivalries between localities.

Those who wish to lead the communes, in other words, the future mayors, are not yet known. Thus, the situation is one in which those who will implement the reform are not taking part in the debate that precedes reform. The risk is that, after they are elected, they may dispute a number of provisions of laws or orders. There is reason to wonder what would happen if the mayors, once installed, would rise up against the fact that they do not chair the health committee, and this would call the balance of this body into question.

10. Conclusions

Territorial reform, which legitimizes the transfer of powers from the State to the communes in rural development (including health), includes provisions that, in many respects, will cause a considerable upheaval in the institutional framework to implement health activities.

However, there is good reason to be enthusiastic that the health sector has embarked on the decentralization option for several years and that this is the precursor of territorial decentralization. With the current organizational system, where the health zone is the hub, the health system has the means for an operational approach, including various partners in co-management bodies which, despite certain limits, continue to provide proof that they are relevant.

The potential difficulties linked to the mismatch between the division into zones and the division into communes seem to have been overestimated, because the scope of powers identified by the law is not creating a place for the joint exercise of responsibilities among communes; their powers stop at the *arrondissement*. Furthermore, the creation of the health committee gives a face to cooperation between communes on the one hand, and between communes and communities on the other hand.

The future of the health zones will to a large extent depend on the health committee's ability to play its role fully. All stakeholders need to be aware of this and must work toward this goal.

For the decision-makers, preserving the health system also means understanding that if health policy is based on political considerations, at the expense of technical considerations for system development, that will undermine all chances of sustainably installing the zone option. It is not only necessary but also urgent for this option to become widespread, given the potential threats from territorial government reform.

People are afraid of reforming territorial government simply because it is misunderstood. It is urgent to fill this information gap so that health sector players, while well aware of the potential threats, are able to take advantage of the considerable opportunities afforded to them.

The health sector is at a crossroads: implementing health reform with many difficulties is not a concept that everyone understands and supports. In addition, people are being asked to adjust to a territorial reform that they did not devise and that is being imposed on them.

But the direction is clear, and the development of a zone system is the only way of giving it the strength to withstand any reform and manage it with ease. That is the key to success.

11. Recommendations

11.1 To the Health Ministry and Donors

1. Broadly extend territorial reform laws and laws on health zones and co-management bodies to all players involved. These include members of parliament, prefects, health workers at the different levels of the pyramid, officials of the Decentralization Mission and *Maison des Collectivités*, members of co-management bodies, health program officers or officers in charge of decentralizing institutions, development partners and donors;

2. Accelerate the process of health zone installation so that they spread throughout the territory;

3. Encourage the effective establishment of drug distribution centers at the level of each health zone to strengthen cohesion in the zone and to allow the zone management team to have greater financial autonomy;

4. Strengthen intersector collaboration by implementing concerted programs between the different sectors, especially to support communities for planning, implementing and monitoring activities;

5. Give the future mayors strong capabilities to plead and negotiate so that optimal use is made of the opportunities for decentralized cooperation;

6. In accordance with the matching philosophy, implement programs to support the future communes to encourage them to use their own funds for health and induce them to enshrine their programs in the framework set up by the health committee; and

7. Encourage the future communes to foster intersector coordination, especially in hygiene, sanitation, and clean water supply, where the law gives them broad powers to do so.

11.2 To the Health Ministry

1. With the ministerial departments involved, begin an analysis of where funds are kept at the commune level for budget line items for all or some of the health workers to ensure that workers are present in the localities to which they are assigned;

2. Transfer to the health zones the funds that represent the State's contribution to zone operation and that are currently managed by the DDSP;

3. Give the health committee the powers of the zone hospital's board of directors;

4. Give the health committee powers in arbitrating conflicts within the COGECs and COGESs, between health works and elected community officials, and between health workers and local elected officials;

5. Make representation in the COGECs more democratic through the presence of agents from the different villages and guarantee equal representation of men, women and youth;

6. Sensitize the people and their leaders that priority should be placed on investments intended for the health zones instead of building new CHDs;

7. Extend the COGESs and COGECs to two representatives of the mayor for properly informing the commune of health activities and the activities of the co-management bodies;

8. Set up DDSPs in the six new departments for closer management of the health zones;

9. Involve the health zones, through the health committee, in auditing compliance with standards for building and outfitting health infrastructure; and

10. Encourage the future commune of Cotonou to allocate substantial resources to health activities, particularly by adopting a municipal health plan commensurate with the needs of the people in the economic capital, and create a health department or unit similar to that of communes in major African urban areas.

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